Influenza and COVID-19 Immunizations Report Form

- Fill in all * *Required fields* * -

CVPs with Provincial E-Form Access MUST Document Directly into the E-Form System

* **Site / Office details** Include FULL site details (Include Location ***AND*** Unit if Acute Care)	HEALTH UNIT STAMP

Client #1 - Information

Or place client demographic sticker here

- * **Name:**
- * **PHN:**
- * **Date Of Birth:**
- * **Gender:**
- **Address:**
- * **Phone:**
- ☐ ***Check box if Health Care Worker***

Immunization information

* Influenza Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ FluMIST ☐ FluVIRAL ☐ FluZONE ☐ FLUAD (65 yrs +)		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
* Lot Number :				

* COVID-19 Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ Moderna - Pediatric (0.25mL) ☐ Pfizer - 5yrs to 11yrs ☐ Moderna - 12yrs+ (0.5mL) ☐ Pfizer - 12yrs+		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
* Lot Number :				

Client #2 - Information

Or place client demographic sticker here

- * **Name:**
- * **PHN:**
- * **Date Of Birth:**
- * **Gender:**
- **Address:**
- * **Phone:**
- ☐ ***Check box if Health Care Worker***

Immunization information

* Influenza Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ FluMIST ☐ FluVIRAL ☐ FluZONE ☐ FLUAD (65 yrs +)		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
* Lot Number :				

* COVID-19 Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ Moderna – Pediatric (0.25mL) ☐ Pfizer - 5yrs to 11yrs ☐ Moderna - 12 yrs+ (0.5mL) ☐ Pfizer - 12yrs+		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
* Lot Number :				